**PURCHASER VALUE NETWORK**

**ACO ASSESSMENT TOOLKIT**

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Section 1</td>
<td>Summary of Accountable Care Domains and Best Practices</td>
</tr>
<tr>
<td>11</td>
<td>Section 2</td>
<td>ACO Principles and Purchaser Expectations</td>
</tr>
<tr>
<td>13</td>
<td>Section 3</td>
<td>Employer Action Guide—ACO Best Practices: Key Questions to Ask</td>
</tr>
<tr>
<td>19</td>
<td>Section 4</td>
<td>Completing a Qualitative ACO Assessment: A Step-by-Step Guide for Employers and Purchaser Coalitions</td>
</tr>
<tr>
<td>21</td>
<td>Section 5</td>
<td>ACO Assessment Discussion Guide Overview</td>
</tr>
<tr>
<td>23</td>
<td>Section 6</td>
<td>National ACO Landscape—Commercial Expansion and Carrier Strategies</td>
</tr>
<tr>
<td>26</td>
<td>Section 7</td>
<td>ACOs and Public Policy</td>
</tr>
<tr>
<td>30</td>
<td>Appendix I</td>
<td>ACO Assessment Discussion Guide for Employer Coalitions</td>
</tr>
<tr>
<td>39</td>
<td>Appendix II</td>
<td>Sample ACO Review Report</td>
</tr>
<tr>
<td>43</td>
<td>Appendix III</td>
<td>Sample ACO Measures</td>
</tr>
</tbody>
</table>
Introduction

As large purchasers search for strategies to improve the quality and affordability of health care for their members, a growing number are working directly with providers or through their health plans to offer Accountable Care Organizations (ACOs). In fact, with the ACO strategies that have been adopted by national carriers and regional health plans, almost all self-insured employers have engaged at some level with provider organizations contracted as ACOs with varying degrees of delegated provider management, member support and care coordination.

ACOs have the potential to deliver high-quality care at reduced costs by improving care coordination and linking provider reimbursements to quality outcomes and utilization results. Further, aligning accountability for total cost of care at the ACO organizational level spurs care integration, efficiency and transformation.

The Purchaser Value Network (PVN) offers employers and employer coalitions guidance on how to qualitatively evaluate provider-based ACO programs through this comprehensive ACO Assessment Toolkit. This Toolkit highlights eight operational and performance domains central to any accountable care arrangement, as well as a set of purchaser-driven best practices in each area. Best practices are gleaned from employers engaged in direct ACO contracts as well as those working with third-party administrators (TPA), fully insured plans, and/or employer benefit consultants to evaluate ACO offerings across the country.
There is a continuum of ACO programs that may be offered through employers’ health benefits:

**Health Plan-Based ACO**
- Existing contracts may limit employer ability to tailor network
- Narrow network design or Primary Care Medical Home configuration
- Physician group-oriented
- Administrative Services Only (ASO), network access, or PMPM fees may apply

**Jointly Developed ACO**
- Employer-designed requirements
- Tailored network
- May include physician group and hospital collaboration
- Gainsharing or risk-sharing options

**Employer-Direct Contracting**
- Employer-designed requirements
- Tailored network
- Risk-sharing or full risk options
- Data sharing between ACO, health plan or TPA for claims and enrollment information, and employer-sponsored health and wellness programs
Section 1. Summary of Accountable Care Domains and Best Practices

Domain

1. Leadership, Governance, Organization and Experience

Definition
The structure and culture of ACO management and governance, including ownership and range of population-based contracts in place. Role of contracting health plan as applicable.

Best Practice

- Leadership includes primary care, specialty and hospital representation, quality management and care coordination director, with input from purchasers and consumers.
- Decision-making processes are transparent to providers.
- Culture supports innovation, rapid cycle quality improvement, information transparency, care redesign.
- Demonstration of experience and aligned strategies across commercial and Medicare ACO and population-based payment programs.
- ACO leverages community collaboratives to share best practices and lessons learned, support workforce development and obtain technical assistance.
- Plan enhances ACO operations through infrastructure support, data sharing, payment and performance incentives, performance reporting and benchmarking, and communication of best practices.
Section 1. Summary of Accountable Care Domains and Best Practices

Domain

2. Member Identification and Engagement

**Definition**

Method to define the population attributed to an ACO (i.e., which members are “in” the ACO); process by which the ACO and its providers identifies and engages members based on their medical and psychosocial needs.

**Best Practice**

- ACO regularly incorporates data from the health plan to identify risk stratification of members who are accessing services from its providers.
- ACO identifies (via electronic medical record or some other indicator) that a member is part of the ACO to assure that every provider touchpoint is utilized to engage the patient.
- ACO uses multiple data sources (e.g., claims, authorizations, admissions and emergency department visits, provider referral) to identify and connect members to ACO resources and support.

---

Domain

3. Provider Engagement, Support and Feedback

**Definition**

Structure of network management (e.g., integrated multispecialty practice, independent practice association or foundation model) and contractual commitments to share data, engage in performance measurement and feedback and care management support.

**Best Practice**

Physicians, hospital and ancillary provider relationship includes:

- Data sharing;
- Performance measurement, feedback and benchmarking, including at the individual physician level;
- Coordinated member engagement and patient handoffs;
- Shared resources such as IT infrastructure, practice-based care coordinators and workforce development;
- Care managers embedded in primary care practices and who provide patient support through primary care or specialty referral to the ACO;
- Collaborative learning/sharing of best practices;
- Bi-directional support of care management processes.

---
Section 1. Summary of Accountable Care Domains and Best Practices

Domain

4. Care Management and Population Health

- Care Coordination
- Medically Complex Patient Management
- Behavioral Health Integration

Definition

Approach to patient risk identification, care coordination and member engagement in care management and support services, including integration of behavioral health services.

Best Practice

- Patients with chronic condition or behavioral health needs are proactively identified and engaged through patient-centered approaches.
- Gaps in care are prioritized based on clinical significance and tailored to patients’ readiness and health goals.
- Patients are routinely screened for behavioral health needs.
- Using a defined process and criteria, medically complex and at-risk patients are proactively identified and receive direct outreach and face-to-face contact, coordinated by or with the primary care physician.
- Community resources are leveraged to address psychosocial needs and environmental barriers to self-care and health risk reduction.
- Patient’s caregiver is engaged in education and care coordination as needed.

Domain

5. Quality Measurement and Improvement

Definition

Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups (e.g., utilizing quality improvement models such as PDSA, FADE, DMAIC, CQI, TQM).

Best Practice

- ACOs and providers are accountable for a comprehensive, but controlled set of high-value measures.
- Clinical outcomes, patient experience and total cost of care are prioritized over process measures.
- A path towards measuring patient-reported outcomes is defined and implemented.
- A clear process of documentation is defined to measure patient-reported outcomes.
- Reporting is timely, transparent and succinct, and shared with payers, leadership, providers and consumers.
- Real-time, actionable information is available to providers.

---

1. PDSA (Plan-Do-Study-Act), FADE (Focus, Analyze, Develop, Execute), DMAIC (Define, Measure, Analyze, Improve, Control), CQI (Continuous Quality Improvement), TQM (Total Quality Management)
### 6. Network Management, Contracting and Financial Model

**Definition**
Structure of provider network (e.g., integrated multispecialty practice, independent practice association or foundation model) and partner hospital and ancillary providers and nature of contractual commitments to share data, align financial incentives, engage in performance measurement and feedback, and coordinate care.

**Best Practice**
- The ACO is structured to provide comprehensive services with sufficient ambulatory, inpatient and ancillary services to optimize access and the site of care.
- High performance specialty providers and preferred inpatient, outpatient surgical and ancillary providers are identified for referring providers.
- ACO leverages alternative payment models to align incentives among providers.
- Financial risk is tailored to organizational capacity and maturity, with a progression to two-sided financial risk with a portion of financial rewards and incentives passed through to individual physicians.
- Hospitals participate in risk-sharing with aligned performance incentives.

### 7. Prescription Drug Management and Optimization

**Definition**
Appropriate and safe drug prescribing and administration, including evaluation of available choices and alternatives to optimize value.

**Best Practice**
- Formulary composition (if applicable) and polypharmacy is monitored.
- High-value drugs are promoted.
- Key quality, cost and utilization indicator reporting is available to prescribing providers, including specialists.
- Prescription drug utilization and infusion is delivered at optimal site of care.
- Payment reform ensures no physician compensation is dependent on or influenced by prescribing practices.
Domain

8. Health IT, Data Integration and Reporting

Definition

Health IT infrastructure and degree of data integration and exchange, across the delivery system and providers, care managers and other suppliers.

Best Practice

- Real-time clinical information is captured and communicated between treating providers.
- Real-time reporting through electronic medical record and/or two-way participation in regional health information exchange (HIE).
- Frequent (at least monthly; daily where feasible) data exchange with health plans, pharmacy benefit managers and relevant data suppliers.
- Electronic medical record or clinical decision support system provides timely information at the point of care to help inform decisions about a patient’s care, facilitate treatment decision support, and improve outcomes.
- Data reporting categories include quality, cost and utilization metrics, using biometric and clinical lab values, medical claims and pharmacy information.
- Analytics include risk stratification and predictive modeling – particularly high-cost high-need patients, gaps in care, adherence to evidence-based medicine and care pathways, provider-level utilization and cost variation.
- Participation in community or other health information exchange networks reduces duplication of services, and supports portable clinical information and comparative effectiveness research.
At the beginning of this decade, large purchasers like CalPERS (California Public Employees’ Retirement System) and Boeing began to pilot accountable care programs. In part spurred by the emergence of the Medicare Shared Savings Program (MSSP) ACOs, established medical groups with managed care experience repositioned themselves as Accountable Care Organizations. Combining lessons from managed care and seeking greater healthcare reform goals, Pacific Business Group on Health promulgated a set of principles about how ACOs should operate. Translated as purchaser expectations, these principles in turn have implications for the transformative role that progressive and integrated provider organizations should play. The following page provides a crosswalk for these guiding principles translated into purchaser expectations for ACOs.

---

Guiding Principles Translated into Expectations for ACOs³

ACO “Guiding Principles”

A high performance network of providers
ACOs offer a defined network of providers selected based on quality, utilization and efficiency.

Outcomes-oriented measurement
ACOs produce meaningful evidence of quality and cost improvements though recognized outcomes and utilization measures.

Patient-centered and coordinated care
ACOs support coordinated care and care-planning support with targeted care management for those who need it.

Cost measurement and savings determination
ACOs can track and reduce overall spending and moderate trend.

Pay for value
ACOs structure payment to support evidence-based care, reward performance, and pass through quality incentives to physicians and hospitals.

Transparency
ACOs are transparent on spending, savings and quality information as well as savings distribution.

Health information technology and administrative infrastructure
ACO utilizes an advanced IT infrastructure to manage population health.

Maintaining market competition
ACO development and growth should advance competition.

Expectations for ACOs

High Performance, High Value Network
• Data systems support access to population level metrics
• Metrics are meaningful and outcomes-based
• There is a roadmap to incorporating patient-reported outcomes
• Providers have access to their performance benchmarked against peers with systematic means of sharing best practices for reduced variation

Patient-centered and Coordinated Care
• Care coordinators are accountable for patient outreach, for coordinating care among providers, and for particular emphasis on identification and engagement of high-risk patients
• Care coordination is a value component of treatment care teams
• Data systems support multi-perspective access to patient charts and care coordination activity logs

Pay for Value
• Total cost of care is trended and reported
• Treating physicians and hospitals are rewarded for outcomes and Total Cost of Care, including pharmacy
• Referring physicians are provided with quality AND cost metrics to support referral and site of care decisions

Maintaining Market Competition
• ACOs compete on metrics of quality and cost
• Enrollees consider ACO value when selecting a care system and have an incentive to consider cost

ACOs have the potential to deliver high-quality care at lower cost by improving care coordination and tying provider reimbursement to quality outcomes and utilization results. However, employers need to take an active role in evaluating ACO offerings, potentially by partnering with their carriers, consultants, and local provider organizations. The following questions can be used by purchasers to measure best practices. More detailed operational questions are presented in Appendix I.
Key questions to ask

Domain

Background and ACO Program Structure

Sample Questions for a Health Plan

- Can an employer opt-out of the program or are members automatically attributed?
- Can an employer select a subset of ACOs?
- What is the cost of accessing the ACO program to the employer?
- Are the fees passed through to the ACO and/or individual physicians?
- How does the health plan fund gainsharing or two-sided risk-sharing payments? Is there a fee-for-service withhold or other amount that the employer needs to accrue? Is there a retrospective credit if the ACO(s) performs poorly?
- What method does the plan use to calculate savings or reliably report trend targets?
- What is the contractually defined scope and division of administrative, financial and operational responsibility?

Sample Questions for a Provider Organization (ACO)

- How many ACO contracts are held by the Provider Organization? What types of health plans (PPO, EPO or HMO)? Direct with purchasers?
- Does the ACO participate in the Medicare Shared Savings Program?
- What payment(s) does the ACO receive from the health plan?
- Are the fees passed through to the ACO and/or individual physicians?
- How does the ACO reconcile health plan calculation of savings or trend targets?
- What is the contractually defined scope and division of administrative, financial and operational responsibility?

GAINSHARING:
Health plan/employer makes a direct payment to the providers based on reducing costs for inpatient services, improving efficiency of care, and meeting quality of care targets.

TWO-SIDED RISK-SHARING:
In a two-sided risk model, the ACO shares in a portion of savings and is at risk for spending over the target.
Domain

1. Leadership, Governance, Organization and Experience

**Sample Questions for a Health Plan**
- What is the plan’s criteria for selecting a Provider Organization for an ACO contract?
- What is the plan doing differently compared to their traditional provider contract relationship (e.g., IT support or data sharing, payment, financial incentives, quality performance requirements, other)?

**Sample Questions for a Provider Organization (ACO)**
- How many ACO contracts are held by the Provider?
- How does the Provider Organization differentiate ACO services for one health plan vs. another health plan (that may or may not have an ACO contract)?
- What is the Provider Organization doing differently compared to its traditional health plan contract relationship?
- What is the ACO’s roadmap for overall performance improvement and managing total cost of care and trend?

Domain

2. Member Identification and Engagement

**Sample Questions for a Health Plan**
- How does the health plan attribute members to the ACO?
- How frequently is member information reported to the ACO?

**Sample Questions for a Provider Organization (ACO)**
- Does the member know s/he has been “attributed” to the ACO?
- Does the treating doctor know when s/he is seeing an ACO-attributed patient?
- What happens when the member accesses services from providers outside the ACO?
Domain

3. Provider Engagement, Support and Feedback

Sample Questions for a Health Plan

- What kind of quality, cost or utilization does the plan report to the ACO?
- Does the plan report organization-wide performance only or also practice and physician-level? Hospital or other provider information?

Sample Questions for a Provider Organization (ACO)

- Does the individual doctor know s/he is part of an ACO?
- What provider commitments are required to be part of the ACO?
- How do providers access physician-level or practice-level metrics?
- How is improvement monitored?

Sample Questions for a Provider Organization (ACO)

- Are ACO-attributed patients getting different care management support than they were prior to the ACO arrangement?
- Does the health plan “turn off” its disease management and case management programs for attributed ACO members?
- If an employer uses a behavioral health carve-out, how are referrals and data coordinated?

Sample Questions for a Health Plan

- Are ACO-attributed patients getting different care management support than they were prior to the ACO arrangement?
- How is the ACO identifying medically complex patients? Is the ACO improving care coordination and addressing the needs of these patients? Are medically complex patients invited to opt-in to special services?
- If an employer uses a behavior health carve-out, how are referrals and claims information coordinated?
Domain

5. Quality Measurement and Improvement

Sample Questions for a Health Plan
- What are the program's success metrics?
- What performance metrics are reported to the employer (quality, cost, utilization, other)?
- Does the ACO have payment rewards or penalties for quality performance?

Sample Questions for a Provider Organization (ACO)
- What performance metrics are used for primary care physicians and specialists?
- What performance metrics (and with what frequency) does the ACO report to its physicians and collaborating hospitals or ancillary providers?
- Are there systematic peer-to-peer quality improvement approaches in place to support care or workflow redesign and monitor progress on metrics?

Domain

6. Network Management, Contracting and Financial Model

Sample Questions for a Health Plan
- Does the ACO become an Exclusive Provider Organization (EPO) or does the member retain access to other providers, i.e., is there an out-of-network benefit?
- Is the ACO responsible for managing the Total Cost of Care, including hospital and pharmacy risk?
- Are the financial incentives based on gainsharing or is there downside risk?
- Are the savings expectations coming from deeper discounts or improved care delivery and reduced waste?

Sample Questions for a Provider Organization (ACO)
- Does the ACO manage a preferred network (steer patients) within the health plan's contracted network?
- Does the ACO pass through financial incentives or performance bonuses to individual providers or are payments still based on fee-for-service?
- Are there any alternative payment models (APMs) in place within the ACO, e.g. bundled payment or physician capitation?
Domain

7. Prescription Drug Management and Optimization

Sample Questions for a Health Plan

- Does the plan include pharmacy costs in setting savings targets for the ACO, and do these include prescription drugs delivered through the medical benefits as well as pharmacy benefits?
- Is the ACO at-risk for drugs administered through the medical benefit? What, if any, carve-outs apply?
- Is the ACO at-risk for prescription drugs delivered through the pharmacy benefit?

Sample Questions for a Provider Organization (ACO)

- If an employer uses a PBM carve-out, how are authorizations and claims information coordinated?
- What proportion of the ACO doctors have access to EMRs that can support patient-specific utilization management, e.g., step therapy and high value prescribing?
- What protocols are in place to optimize the generic prescribing rate? High-value prescribing? Step therapy or clinical utilization management?

Domain

8. Health IT, Data Integration and Reporting

Sample Questions for a Health Plan

- What types of information does the health plan provide the ACO, and with what frequency (e.g., medical and pharmacy claims, hospital admissions, emergency department visits, authorizations, use of non-preferred providers, etc.)?
- What types of information does the health plan collect from the ACO?

Sample Questions for a Provider Organization (ACO)

- What types of information does the health plan provide the ACO, and with what frequency is the data processed (e.g., risk stratification)?
- Are there data not provided by the plan that the ACO believes is important for operations and clinical management?
- Does the ACO administer a common electronic medical record platform for its providers? If yes, what percentage of physicians use it? If no, how does the ACO exchange clinical information with its providers?
- Is there real-time information exchange and communication among treating providers? With care coordinators?
- Do care coordinators access the same data as treating physicians? For what proportion of ACO patients?
Section 4. Completing a Qualitative ACO Assessment: A Step-by-Step Guide for Employers and Purchaser Coalitions

Recognizing that the transition to high-value accountable care is an evolution, and that measurable quality and cost savings results may not be immediate, there is value in assessing the degree to which best practices and processes are implemented to support higher value care over a longer time horizon. Regional health care coalitions are well positioned to provide this assessment for their collective set of purchaser members or for individual purchasers for whom the performance of a specific ACO has substantial impact.

Pre-Meeting
Collaborating health plans can help to identify participating provider organization and the key contact within that group. During the scheduling process, the business group should send the sample interview guide (Appendix I) to the key contact to ensure that the provider organization identifies the best participants for the meeting. Ask the key contact if it is permissible to record the meeting for note taking purposes; confirm that the recording will not be distributed.

Key Participants
- **Medical Group**—Medical Director, Contracting Manager, Care Management Coordinator, Pharmacist Manager (if there is one), others welcome but optional
- **Business Group**—Interview Facilitator, Scribe
- **Health Plan**—Welcome, but optional
Meeting Process

The Interview Facilitator will take the lead on determining which questions to ask and in which order. The Facilitator will start with the first question in each category and may or may not use follow-up questions based on the response to the initial question. At their discretion, the Facilitator may also ask additional questions.

For each interview, there will be a person (the “scribe”) designated to document the responses and other relevant discussion that occurs during the interview. The scribe may also contribute questions and/or enhance the questions by adding follow-up questions.

It is not necessary for Business Group participants to have clinical backgrounds, but it is imperative that both have an understanding of delivery system operations.

Post Meeting

The Business Group will prepare a written report and summary chart of the interview. A sample reporting template is provided as Appendix II. The business group will send the reports to the provider organization for any corrections, and then prepare a presentation for reporting findings to employers, and as applicable, to the health plan.
Appendix I includes a detailed discussion guide to support ACO Process Reviews that are conducted as part of a site visit to a provider organization. The goals of the process reviews are to understand the structure of the organization, systems and operations for delivery of accountable care.

How does the organization engage and communicate with members (including attributed individuals who may have limited, if any, relationship with the ACO’s providers)?

How is care integrated and coordinated to support member needs across the continuum of health and risk?

How does the organization engage and support its providers?

The Discussion Guide is organized into the following areas:

1. Leadership, Governance, Organization and Experience
2. Member Identification and Engagement
3. Provider Engagement, Support and Feedback
4. Care Management and Population Health
   • Care Coordination
   • Medically Complex Patient Management
   • Behavioral Health Integration
5. Quality Measurement and Improvement
6. Network Management, Contracting and Financial Model
7. Prescription Drug Management and Optimization
8. Health IT, Data Integration and Reporting
The goals of the process reviews are to understand:

- How services may differ from one ACO to another – even under the same health plan contract
- Delegation and coordination of services between the health plan and ACO, i.e., how effective is the ACO-health plan partnership; what is different for Health Plan PPO (or EPO, HMO) compared to any other population the ACO is managing?
- Systems the ACO has in place to manage overall population health, coordinate care, and support medically complex patients with high costs and high needs
- Best practice and success factors for the ACO in managing quality and financial risk for a PPO population
- How services may differ from the care that members were receiving prior to the establishment of the ACO contract
- Roadmap for incorporating not-yet-in-place best-in-class ACO processes, including patient-reported outcomes, physician-specific benchmarking, robust point-of-care decision support, etc.
Accountable care strategies have proliferated among national carriers and regional health plans. While most ACO program designs have a gainsharing component, a limited number of these contracts include two-sided risk. Commonly, a per member per month (PMPM) fee or network access fee is collected to fund care management and/or performance incentive payments.

**Employers should attempt to fully understand:**

1. The monthly fees assessed by health plans for attributed and opt-in ACO models, and potential financial liability for future gainsharing payments.

2. The quality measures, performance targets and quality improvement trends.

3. The average total cost of care for the employer’s attributed population per ACO with year to year trending. Methodology and any exclusions should be transparent.

4. The health plan’s expansion strategy for additional contracted ACOs over the next one to three years.
Below is a summary of programs offered by national carriers. Key distinctions include UnitedHealthcare’s Nexus ACO and Aetna’s Whole Health Products, both of which are opt-in contained designs. The Anthem design is unique in that it includes a designated care coordination fee for high-risk attributed patients, i.e., those with 2+ chronic conditions.

### Employer Perspective
- Attribution ACOs with a PMPM fee. There might be retroactive adjustment if goals are not met. Embedded in Choice POS II and Aetna Select
- Whole Health Product. Side by side opt-in, closed product. Substantially reduced fee schedule with shared savings withhold

### Provider Perspective
- Attribution ACOs. Shared savings P4P bonus
- Whole Health Product. Two-sided risk

### ACO Sites
- 48 Whole Health Markets
- 80 ACO Contracts

### Provider Perspective
- Gainsharing subject to quality performance. PMPM is pooled and allocated to groups meeting performance threshold. PMPM and gainsharing replace routine fee schedule increases; adjustments may vary state to state
- P4P shared savings bonus plus a monthly care coordination fee for chronic +2 attributed members. Ongoing care coordination fee subject to meeting savings and outcomes metrics

### Employer Perspective
- Enhanced Personal Health Care with some regional variation in fee structure
- PMPM fee for attributed members
- Additional PMPM care management fee for population identified with 2 or more chronic conditions
- No retroactive adjustment if ACO underperformed

### ACO Sites
- 151
- Additional sites through BlueCard network
**Employer Perspective**

- Cigna Collaborative Care
- Care coordination PMPM fee based on attribution. It might be adjusted going forward if targets are not met
- Retroactive shared savings bonus charged as a line item fee

**Provider Perspective**

- Gainsharing subject to meeting quality performance and medical cost targets

**ACO Sites**

- 173

---

**Employer Perspective**

- Value-based contracting PMPM fee for attributed members. No retroactive adjustment for employers with attribution to underperforming ACOs
- NexusACO. Opt-in “buy-up” ACO with mandated PCP selection
- Benefit design incentive to use Tier 1 providers

**Provider Perspective**

- Shared savings bonus with quality performance metrics

**ACO Sites**

- 87
- 18 Nexus ACOs

---

1 As of May 2017
5 NexusACO: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=d3401088b7f28510Vgv/CM2000001b406a0a
Recent Medicare policy has had a significant influence on the provider landscape and accordingly, on commercial plan experience. In this context, it is useful to understand the history and lessons learned from the various Medicare Shared Savings Program (MSSP) experiments.

The Department of Health and Human Services (HHS) has been working in concert with private payers and purchasers to transform the nation’s health system to emphasize value over volume. HHS set a goal of tying 30% of Medicare fee-for-service payments to quality or value through alternative payment models by 2016 and 50% by 2018. Moreover, coalitions can support purchasers’ engagement in influencing Medicare policy moving forward.

Medicare has a suite of ACO programs: Medicare Shared Savings Program (MSSP), the Pioneer ACO Model and Next Generation ACO Model. The programs are collectively designed to advance alternative payment models and provide a pathway to global payment.

The MSSP has three pathways for participation: an upside-only shared savings (Track 1) and two upside/downside shared savings/losses (Tracks 2 & 3), with Track 3 at a higher level of risk and design elements to encourage participation. Despite these incentives, most MSSP ACOs are in Track 1.

**ALTERNATIVE PAYMENT MODELS (APM):**
An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode or a population.

**GLOBAL PAYMENT:**
The ACO receives a payment from the payer for the enrolled population and is responsible for providing specified health services and managing total cost of care.
The MSSP has grown to 480 ACOs in 2017, with 91% in Track 1. The Pioneer model was designed for those already experienced with coordinating care across settings and included upside/downside shared savings/losses that transition to population-based payment after two years.

Pioneer started with 32 ACOs in 2012 and concluded with eight in 2016 as organizations exited and transitioned to other MSSP models. The Next Generation model includes even stronger financial incentives and risk-sharing options, plus some unique design elements like benefit enhancements. While the number of beneficiaries covered under Medicare ACOs continues to rise, it only represents about one-third of the population served by ACOs.

### 2015 Results Shed Light on Effectiveness

Of the 392 ACOs participating in the MSSP, only 119 ACOs reduced spending enough to share in the savings; 83 ACOs reduced spending but not enough to earn shared savings. Six of 12 Pioneer ACOs earned shared savings, with two generating savings below the shared savings benchmark.\(^\text{11}\) Groups with more experience (those who joined the program in 2012) were nearly twice as likely to achieve shared savings as those joining in 2014 and 2015. That means about half generated losses. In total, MSSP generated savings of $429 million, though the federal government actually lost $216 million on the program as a result of $646 million in payments to high performing ACOs. High performance was relative, however,

---

\(^{10}\) Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs), January 2017. Accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf

insofar as ACOs receiving shared savings had significantly higher financial benchmarks per beneficiary than those that did not. There is modest improvement on quality measures. Notably, though, Medicare ACOs tend to perform better on quality metrics than other Medicare fee-for-service providers.

Results from the Pioneer model indicate many successfully met spending and quality targets. However, this does not account for the attrition from the program. Some ACOs left Pioneer because they did not fare well, citing the benchmarking methodology as detrimental to those in already efficient markets. Overall, eight Pioneer ACOs generated $37 million in savings in 2015. Of the four Pioneer ACOs that generated losses, one produced losses outside the minimum loss rate and owed shared losses. All 12 Pioneer ACOs improved their quality scores from the onset of the program through 2015, with a total mean quality score increase of 21 percentage points.

More Needed from Medicare ACOs to Realize Potential

Although Medicare represents only one-third of the ACO market, it does exert influence. While the private sector has expanded on Medicare ACOs with customized network designs and service support. Medicare is the biggest payer for many providers so it wields significant influence on their decisions.

The mixed results to date show that Medicare ACOs still have further to go to achieve the full potential of coordinated, patient-centered, affordable care. In 2015, CMS relaxed the requirement about when ACOs must move to two-sided risk to stay in the program. While this may give more time to ACOs to build the necessary infrastructure to survive in a risk-bearing environment, it does come at a cost. It remains a question of whether or not differential MACRA incentives for two-sided risk will be enough to entice ACOs to switch to two-sided risk. What is evident from the results, though, is that upside-only shared savings is not sustainable for the public program.

Among groups that withdrew from the Pioneer program or that never elected to participate in MSSP, the methodology for financial performance benchmarking is challenging for organizations currently operating in lower cost areas. While groups in high cost regions can reap significant savings from reduced utilization and avoidable duplication and waste, groups in lower cost regions are challenged in achieving the requisite savings. Significant opportunities remain in the Medicare fee-for-service market, which may benefit from a second look for win-win opportunities.

What Advocacy Opportunities Are Available to Purchasers?

Purchasers can and should play an influential role in shaping the healthcare landscape not only through their purchasing practices but by making their voices heard. Actions that purchasers can take include:

- Teaming up with other purchasers, coalitions and other like-minded allies
- Influencing public policy through comments on proposed regulations, requests for information and conversations with policymakers
Section 7. ACOs and Public Policy

• Educating through public speaking opportunities, social media and written materials

In the policy arena, federal activity on ACOs is largely addressed through regulatory processes with some legislative potential from time to time. Additionally, some states are active in Medicaid and all-payer accountable care programs. Private purchaser alignment with such efforts helps create critical mass for impacting provider practice organization and redesigning care. When it comes to influencing the policy arena, strength in numbers is an important strategy. Therefore, employers should join like-minded purchasers or regional and national coalitions to make their voice heard. This also mitigates concerns about being in the spotlight or having enough resources to effectively participate. In summary, ensuring a purchaser perspective is included in the dialogue on ACOs is a valuable contribution.

While a monolithic approach is not workable with complex market drivers that differ across regions, employers should remain particularly diligent about:

Payment that Drives Care Delivery Transformation - ACOs need to move away from fee-for-service payments and shared savings models. This includes making a transition to payments that involve the assumption of greater financial risk – two-sided risk, partial capitation or full capitation. It also means that not all ACOs will continue down the path.

Quality Measures that Drive Meaningful Accountability - Performance measurement is integral to improving care delivery as well as evaluating success of ACOs. Measure sets should focus on clinical and patient-reported outcomes, patient experience and care coordination. Moreover, because it is not feasible for measurement and reporting to take place at the ACO-level alone, health plans should align quality metrics to provide broader-based population measurement and support the ACO in supplying timely and actionable information to the provider. A proposed set of common ACO quality measures is included as Appendix III.

Care that Supports Patient Engagement - While providers are ultimately accountable for the cost and quality of care delivered within an ACO, patients can and should play a critical role in improving their own health. ACOs should be take responsibility for effectively engaging them to do so. This includes outreach via various modalities, informed coaching utilizing principles of motivational interviewing and goal-setting, and population health approaches to support targeted communications.

Consolidation Driving Prices Up - Many factors, including the accountable care movement, have contributed to the continuing growth of mergers and acquisitions. While this may result in better care coordination, as organizations gain a stronger market presence, their ability to get top dollar increases. Having safeguards in place to promote competition and counteract abuses of market power is critical to reducing the total cost of care for private purchasers.

Appendix I. ACO Assessment Discussion Guide for Employer Coalitions

The following discussion guide was created by the Pacific Business Group on Health in collaboration with Anthem to support Provider Organization Process Reviews. The goals of the process reviews are to understand the structure of the organization and systems and operations for delivery of accountable care. Both the health plan and ACO perspective are important in understanding how well services are integrated and coordinated to support member needs across the continuum of health and providers.

Working with its employer members, a coalition may also elect to conduct a deeper dive that may include case reviews and audit of clinical processes.
Leadership, Governance, Organization and Experience

1. Describe the leadership and governance of the organization.
   a. Who is on the Board and what groups are represented by these individuals (primary care, specialists, leadership from key hospitals, other stakeholders, etc.)?
   b. How often does the Board (or Executive Committee) meet?
   c. How are decisions communicated to constituents?
   d. Does the Board include consumers and purchasers?
   e. Who owns the organization?

2. How is this group organized? Medical group, IPA, both?
   a. Do you have employed physicians?
   b. What is the mix of your employed vs. contracted doctors; PCPs? Specialists? Mental health providers?
   c. In the case of non-employed doctors, please indicate the proportion that are exclusively treating your patients. (Can you report this by PCP and specialists?)

3. What portion of market-share does this health plan represent in your total business?
   a. What proportion of the health plan’s members are attributed to the ACO?
   b. What proportion of business is PPO business vs. HMO business?
   c. What proportion of this ACO patient population is treated by doctors on your HMO platform?
   d. In addition to the PPO platform that supports this ACO contract, do you also operate an HMO?

4. How many ACO or population-based contracts are held by the organization?
   a. Medicare Shared Savings Program participation or other Medicare pilot programs?
   b. Other commercial ACO contracts?
   c. Length of time and volume of membership?
Member Identification and Engagement

1. Please describe the initial intake process (please differentiate answers for medically complex patients vs. attributed patients)
   a. In person or via telephone?
   b. Is enrollment in this health plan’s ACO opt in or opt out?
   c. Is “patient engagement” or “readiness to change” assessed during this or some other process?
   d. What is the frequency and nature of ongoing member contact barring specific needs or issues (routine contact)?

2. What is the typical mode for patient communications? Which of the following methods does the group employ and for what purpose?
   a. Letters
   b. Phone calls
   c. Interactive Voice Response (IVR)
   d. Email
   e. Patient Portal
   f. Other

3. Does the ACO tailor communications based on the needs of the patient (i.e. high risk, mental health, socioeconomic factors)?

4. Does the patient have the ability to electronically view, download, and update personal medical information?

5. How does the ACO ensure timely access to care?
   a. Easy appointment scheduling with same-day availability based on acuity? How long does it take for a patient to obtain an appointment?
   b. Increased 24/7 patient, family and caregiver access (nurse advice line, after-hours call center, and/or telemedicine consultation) to providers who know the patient and have access to the patient’s EHR?
   c. If the ACO offers a telemedicine option, please describe how it interfaces with the patient’s PCP’s record of care (i.e., how is it integrated with the patient’s conventionally received care?)
   d. Do care coordinators receive next day notification about patient outreach?

6. How does the ACO provide information about patient rights and opportunities for redress/recourse and second opinions?
Appendix I. ACO Assessment Discussion Guide for Employer Coalitions

7. What assessment tools are part of the enrollment process? (Psychosocial, depression, other behavioral health)?
   a. Are these repeated at periodic intervals?

8. Does the ACO support an infrastructure of “support” groups for special needs, e.g., cancer support, weight-loss support, etc.? Please describe.

**Provider Engagement, Support and Feedback**

1. Is there PCP or PCP office partnership with care coordinators for intake?

2. How does the ACO document and/or systematically check that recommended referrals have been acted upon?

3. Does the ACO alert specific PCP providers that a specific patient has been attributed to him/her?
   a. If so, is there a feedback loop to gather information from the PCP about the patient, to communicate back to care coordinator (and likewise back to the physician again as appropriate) on a regular basis as updated information is received from health plans? Please describe.

4. Are there non-physician clinicians notified of the patient’s attribution and clinical status?
   a. What is the professional delineation of your non-physician practitioners? How many of each of the following specialties do you have on staff and generally speaking, how many patients can they manage at one time?
      i. Social workers?
      ii. Diabetes educators?
      iii. Nurse Practitioners?
      iv. Other?

5. Is there a “team” approach? Please describe what the team looks like and how they operate.

6. Is the chart or EMR marked for easy identification of attributed patients by all who access it?

7. Does the medical group have a process and system that supports clinician (e.g., physician, etc.) referral of patients into care coordination who may not be automatically attributed?

8. Does the treating clinician receive feedback about the patient’s engagement in the recommended care management protocol?

9. Do ACO physicians get referral support, i.e., information informing them about high value providers to whom they should refer?
Care Management and Population Health

- Care Coordination
- Medically Complex Patient Management
- Behavioral Health Integration

1. Does the ACO risk stratify each member based on severity of illness(s) and intensity of services? Please describe.

2. Do care coordinators (or PCPs) routinely capture data on:
   a. Smoking status?
   b. BMI?
   c. Lifestyle, e.g. exercise, alcohol use?
   d. Important social determinants, e.g. domestic violence risk or family stress?
      i. Does the ACO have any partnerships with community organizations and social services agencies (e.g., housing, food assistance, transportation)?

3. How is care coordinated between primary care and mental/behavioral health professionals?
   a. What is the referral process for patients at risk for depression?
   b. Are clinical records exchanged between medical and mental/behavioral health providers?
   c. Is there an integrated care plan for primary care and mental/behavioral health?
   d. Recognizing that there might be a mental health carve-out plan, does the referral process consider the patient’s benefit design and impact of using network or non-participating providers?

4. What is the group doing different now with regard to care coordination than prior to the ACO contract with the health plan?

5. Do the patients enrolled in this health plan's ACO have care management or care coordination that is different from other health plans' ACO members? Please describe. (Note: the point of this question is to assess how the group administers varying ACO contracts across plans).

6. What are the staffing ratios for care coordinators to attributed patients?

7. Are care coordinators embedded within primary care practice sites, centralized, or both?

8. Do the ACO care coordinators conduct home visits?

9. Does the ACO staff conduct daily or weekly care coordination huddles to risk-stratify/tier
case load and discuss cases? Please describe.

a. Are shared decisionmaking techniques included in clinician training and is its use promoted?

b. Are motivational interviewing techniques included in clinician training and is its use promoted?

c. Is there ongoing training?

d. What ongoing monitoring exists to assure quality improvement around these proven techniques?

e. Are there any carve-outs (behavioral health, cancer, end-stage renal disease, etc.)?
   i. If so, does the ACO coordinate with a warm handoff to assure that there is someone to take care of the patient on the other end?

10. Please describe the role the care coordinators play in transitions of care? (This includes to specialists, ER, Hospital, SNF, Rehabilitation, Outpatient treatments and services, Home Health, DME, and Behavioral Health) Or does the ACO have systematic processes around smooth transitions that do not involve care coordinators?

   a. What services are provided to patients deemed at high-risk for readmission?

Quality Measurement and Improvement

1. Please describe the monitoring system and metrics the ACO uses to provide information about:

   a. Number of patients outreached and enrolled
   b. Utilization metrics
   c. Clinical and quality metrics (can you provide a list of the quality metrics you routinely evaluate?)
   d. Patient engagement
   e. Patient experience (patient satisfaction)? Patient Assessment Survey (PAS)? Other?
   f. Patient Reported Outcomes Measures?
   g. Patient total cost of care?

2. Does the ACO use measures that differ from the measures required by the health plan?

3. Do different health plans require different measures from the ACO?

4. What measures does the plan routinely report to the ACO, and with what frequency? Does the ACO use this information for quality improvement?
5. What change(s) have been most impactful in the ACO improving quality of care or reducing total cost of care (i.e. most impactful at increasing value)?

6. How does your operational infrastructure enable and support quality improvement?
   a. What methods are used in structuring quality improvement activities (e.g., Lean, Total Quality Management, Plan-Do-Study-Act, etc.)
   b. What training does the ACO provide to care coordinators and other members of the care team? How are new staff integrated? Are staff recertified on an annual basis or other frequency?
   c. In what ways do you support or train physician office staff in modifying workflow to improve patient experience, care coordination and data capture for quality measurement?
   d. How do you instil a culture of ongoing quality improvement throughout the organization?

**Network Management, Contracting and Financial Model**

1. Recognizing that the ACO enrollment is PPO-based, what efforts does the organization undertake to steer members to:
   a. Higher-performing specialists?
   b. Hospitals?

2. What is the primary hospital for ACO patient referrals?

3. How do you communicate that hospital preference to your ACO doctors?

4. Does the ACO partner with the health plan to determine expected costs, cost savings, cost thresholds?

5. Does any portion of the health plan’s added payments to the group filter to the specific treating PCP?
   a. If so, how is that determination made?

6. What is the financial arrangement between the group and the ACO hospital? Any shared risk?
Prescription Drug Management and Optimization

1. Is a patient-specific drug review and reconciliation routinely performed on ACO patients?
   a. Does the ACO consider the drug benefit of the enrollee when making prescription decisions, e.g. with regard to step therapy? Plan formularies? How is this operationalized?
   b. Does the ACO consider the drug benefit of the enrollee when making prescription decisions, e.g. with regard to step therapy? Plan formularies? How is this operationalized?
   c. Does the ACO routinely consider the site of administration for drugs like Remicade to avoid hospital-based, unnecessarily expensive administrations?
   d. Does the ACO interface with care managers provided by PBMs in cases of specialty prescriptions?

2. What incentive exists for prescribing doctors to consider lower tier drugs when prescribing?
   a. Do prescribing physicians receive benchmark reports informing them about their practice patterns as compared to other physicians with regard to drugs? With regard to diagnostics?

Health IT, Data Integration and Reporting, including Data Support from the Health Plan

1. What is the health information strategy for patient information and for performance measurement?

2. What is the EMR and/or CM Software system used to support clinical care and care coordination?

3. Do the care coordinators access the same system as other treating clinicians?

4. Does the ACO have access to patient EHR data?
   a. For all providers?
   b. If not for all providers, for what percentage of providers?
c. Is the access to all EHR data, or just specific measures?

5. What information do you get from the health plan to support patient identification? With what frequency?

6. Does the information from the health plan alert the ACO about:
   a. High-risk individuals (chronic +2 or some other definition?)
   b. Attributed individuals? I.e., does the ACO get “advance” notification of attributed patients (non-medically complex) or at the end of the measurement period?
   c. How often is the high-risk patient information refreshed with health plan data?

7. Does the ACO integrate information about patients with the data supplied by the health plans to better understand the specific clinical profile of attributed patients? Please describe.

8. What role does pharmacy data play in the ACO’s identification/stratification of patients?
   a. How timely is the pharmacy data that the ACO receives?

9. Is the ACO notified by the health plan when there is an Emergency Department or Hospital admission or readmission?
   a. What is the timeframe relative to the occurrence?
   b. Is this notification for all health plan ACO patients?
      i. Those identified as high risk only?
      ii. All patients from the health plan in general?

10. What are the strengths and weaknesses of the data the ACO receives, i.e., what data set(s) are most useful?

11. Does the ACO support telemedicine or virtual visits? Does the ACO support secure email communications? Please describe.
On behalf of its Members, the Business Group collaborated with Health Plan to interview leadership from Provider Organization contracted for the Health Plan’s ACO program. The ACO contract for self-funded and insured (PPO, HMO) members was effective Month, Year. Purchasers are interested in better understanding the types of services that are being provided through the ACO provider organizations with which they contract and/or for which they pay a Per Member fee for attributed patients. This process review will assist employers in exploring opportunities to promote ACO enrollment, develop complementary provider organization partnerships, understand operational strengths and identify opportunities for improvement. For some employers, their geographic footprint might lead to opportunities to coordinate provider organization services with workplace programs such as onsite employer clinics and wellness initiatives.
The goals of the process reviews are to understand:

- Systems the Provider Organization has in place managing overall population health, coordinating care, and supporting medically complex patients with high costs and high needs;
- Best practice and success factors for the Provider Organization in managing quality and financial risk for a PPO population;
- How services may differ from the care members were previously receiving prior to the establishment of the ACO contract;
- How effective is the ACO-health plan partnership? What’s different for Health Plan enrollees vs. any other population the Medical Groups are managing?
- Roadmap for incorporating not-yet-in-place best in class ACO processes, including patient-reported outcome measures, physician-specific and practice-level benchmarking, robust point-of-care decision support, etc.

What follows is a high-level summary of the interview with Provider Organization. The discussion guide outlined in Appendix I was designed to be an informational interview structured around key provider organization processes and operations, and not a program audit. This preliminary summary report includes observations [and comparative results, if applicable].

Provider Organization Name, Location, Date

Narrative

(Include a short summary description and distinguishing elements of each domain. Example and numbers included here are for illustrative purposes). Where applicable, discuss status and/or progress towards Best Practices.

Leadership, Governance, Organization and Experience

Group employs 125 physicians through its foundation model and contracts with an additional 250 through an Independent Practice Association (IPA) structure. About 65% of the ACO’s inpatient population is treated by Hospital, with whom the Provider Organization has a data sharing arrangement. Governance includes primary care, specialty and hospital representation, quality management and care coordination director, with input from purchasers and consumers. Senior leadership, led by Dr. Brenda Jones, is committed to this group’s transformation to an ACO as evidenced by their experience direct contracting with Joe’s Tires Company and interest in more direct contracting relationships. Currently, 22% of the group’s patient population is attributed or enrolled in a health plan or direct contract ACO arrangement.
Group holds commercial ACO contracts with Health Plan[s]. Plan support includes [monthly] eligibility and claims data reporting, admission and service authorization notification, and performance benchmarking. Group providers infrastructure support, including Electronic Medical Records (EMR), staff training and practice redesign. Group also participates in the [Medicare Next Generation ACO] model and accepts risk for financial performance under Track [#].

**Member Identification and Engagement**

Members are attributed to Group based on health plan attribution to primary care physicians (PCPs) based on claims analysis. Under a limited number of benefit designs, members are also attributed based on primary care physician selection, representing 5% of commercial ACO. Members attributed by health plans are flagged in the EMR, which is used by 100% of employed physicians and 20% of independently contracted physicians. IPA physicians receive a [monthly] list of attributed members and are notified about care management interactions with Group health coaches and staff. At-risk or high-need patients are identified through risk assessment and physician referral. Members with poorly managed chronic conditions or medically complex needs are contacted via [telephone, letter and/or physician referral]. Efforts extended to enroll those targeted in an opt-in care management/coaching program have a reach rate of 75% with an overall enrollment success rate of 37%. Additionally, other attributed members are managed using software [name] to identify gaps in preventive care and outreach via US mail and email when available.

**Provider Engagement, Support, and Feedback**

Group is both a Foundation and an IPA model, with 60% of its PCPs employed through its Foundation and 40% contracted through its IPA. IPA-based PCPs are required to enter into an opt-in agreement with the ACO wherein they agree to share medical record information, refer to specialists and hospitals working the ACO, and acknowledge care coordination interactions with the member. Among specialists, 85% are contracted through the IPA. The overall ratio of PCPs to specialists is [1:1.8]. Group provides quality measurement, utilization, and financial performance feedback and benchmarking at the individual physician level and practice level through quarterly reports. Employed physicians have access to ad hoc performance dashboards through an online portal.

Care coordination interactions are entered into the EMR, [with/without] PCP notification. For high-risk members, the frequency and content of care coordination department huddles are also documented. Behavioral health services are integrated to the extent possible, with the health plan providing an eligibility flag for attributed individuals with mental health services that are carved out.
For IPA-based physicians, PCPs are notified about care coordination interactions via email [or fax]. PCPs provide acknowledgement of case review notes or recommended follow-ups. Care coordinators may obtain expedited same-day appointments for ACO members. PCPs may also refer attributed members for care coordination outreach. Care managers may be embedded in primary care practices or may provide patient support through primary care or specialty referral to the ACO.

[Hospital] provides real-time Emergency Department and inpatient admission notification to the ACO; ACO notifies hospital of elective admissions authorized by [Group and/or Health Plan]. ACO offers clinical, operational and administrative support to participating providers.

Group meets individually with PCPs to review provider-specific feedback reports regarding variation in quality and efficiency, including specialty utilization (referral cost), drug optimization (generic use rate, substitution) select modifiable services such as advanced imaging, emergency department and/or hospital use rate (especially avoidable ED or inpatient admissions rate).

**Care Management and Population Health**

Members with chronic conditions and/or behavioral health needs are proactively identified through risk stratification software. [Name] is applied to the last 12 months of claims [and EMR] data to identify the top 20% in terms of prospective risk, illness burden and/or future cost, who are then assigned to the care coordination team’s outreach list. Patient gaps in care are prioritized based on clinical significance. Care management may include intake of periodic patient assessment tools, outreach and interventions to address gaps in care and recommended preventive services, referrals to specialists, community resources and services, frequency and documentation of patient contact.

*Address whether care coordinators address psychosocial needs and environmental barriers to self-care and health risk reduction. Discuss how behavioral health services are integrated.*

*Discuss how care transitions, such as a hospital discharge or transfer of specialty care, are managed.*

*Discuss how use of non-preferred physicians and/or hospitals is addressed and whether admissions to non-preferred hospitals are repatriated to the ACO’s primary hospital[s].*

**Quality Measurement and Improvement**

Group uses quality, utilization and financial measures to monitor overall performance of the ACO. Key performance indicators include [*list: total cost of care, clinical outcomes, patient experience*]. Indicate whether the ACO relies primarily on traditional clinical process measures
or if it has a documented roadmap to capture clinical outcomes, as well as to incorporate patient-reported outcomes.

Performance measures are reported [quarterly] to participating providers, with metrics and methodology documented and transparent to physicians [and hospitals]. PCPs are given actionable information such as patient lists with identified gaps in care or prescription drug management opportunities. The ACO provides staff training and practice management support to improve workflow. Collaborative learning and sharing of best practices are disseminated through [quarterly] management sessions.

Provide description for how care coordinators are trained, including any ongoing training and/or recertification.

**Networking, Contracting, Management and Financial Model**

The ACO manages a comprehensive network of providers, including sufficient ambulatory, inpatient and ancillary services to optimize access and the site-of-care. Beyond its primary hospital relationship, the Group’s admissions are distributed among [number] regional hospitals. The ACO has on-site care coordinators at [number] of hospitals, and relies on health plan notification for [25%] of its hospital admissions and emergency department visits. The ACO offers options for telehealth and other means of virtual access. High performance specialty providers and preferred inpatient, outpatient surgical and ancillary providers are identified for referring providers.

The ACO accepts financial risk based on [total cost of care, targeted global budget, managing to targeted inpatient and emergency department utilization levels], inclusive/exclusive of prescription drug costs. Hospital payments are [budgeted separately, part of the targeted global budget], for which the ACO [has potential downside risk up to X%/is not at risk]. Contracts include threshold quality performance metrics and [upside only, upside and downside] financial risk. ACO passes through 20% of performance payments to its primary care and specialty providers. Employed physicians have a fixed salary and performance bonus structure of up to 20%; IPA physicians are compensated primarily on a fee-for-service basis.

*Indicate the extent to which ACO uses alternative payment models to align incentives among providers, including portion of payments under such models. Examples may include bundled or episode-based payments, capitation or reference pricing. Indicate if hospital[s] participate in risk-sharing with aligned performance incentives.*

*Provide description for how information is shared between the health plan and provider organization to understand quality and efficiency performance, methodology for shared savings and/or risk calculation, distribution and timing of performance payments, including how any care coordination fee is utilized.*
Prescription Drug Management and Optimization

The ACO manages prescription drug management by tracking formulary adherence, generic prescribing efficiency rate, and site of service for specialty drugs. The ACO management team includes a pharmacist to support polypharmacy review and case coordination with care managers. The pharmacist interacts with ACO providers to optimize prescription drug management. Key quality, cost and utilization measures include chronic medication possession rates, generic dispensing rates and adherence to step therapy protocols that promote use of high-value medications.

Describe the extent to which site of care is managed for specialty drugs and infusion therapy. Discuss use of alternative payment models and or reference pricing to manage drug costs. If applicable, address the portion of ACO commercial membership who may be subject to a prescription drug carve-out benefit.

Health IT, Data Integration, and Reporting

For the employed physicians and IPA providers on the EMR platform, the system provides ready access to care coordination provided through the ACO staff. Additionally, the clinical decision support system provides timely information at the point of care to guide recommended diagnostic services, optimal drug prescribing (and potential drug interactions), specialty referrals, and treatment decision support. Real-time communication between treating providers and care coordinators to help inform decisions about a patient’s care, reduce potential duplication of service, and support caregiver engagement.

Describe how IPA providers not on the EMR platform exchange data and information with the ACO consistent with sections above.

The ACO conducts data analytics that include risk stratification and predictive modeling particularly high-cost high-need patients, gaps in care, adherence to evidence-based medicine and care pathways, provider-level utilization and cost variation.

Indicate periodicity and how information is conveyed to providers via push communications or direct provider access; if latter, indicate the extent to which ACO monitors provider use of the IT platform.
Participation in community or other health information exchange networks reduces duplication of services, and supports portable clinical information and comparative effectiveness research.

*Provide description for how the ACO program performance is monitored, including how Health Plan data is utilized, software systems, how the metrics are reported back to the Health Plan, etc.*

**Other Highlights**

*Provide description for any other program elements to highlight, including opportunities for engagement with the business coalition and community collaboration. Summarize major strategies and direction of the ACO, such as growth plans or change in financial risk-bearing arrangements. Other topics may include administrative efficiency, staff levels, staff optimization to maximal skill/licensure.*
Appendix III. Sample ACO Measures

As ACOs have proliferated, so have the variety of performance standards, quality measures and reporting metrics in use by purchasers, health plans and provider organizations. While purchasers prioritize accountability for health outcomes and the total cost of care, health plans and providers may also use a variety of measures geared to quality improvement and reducing care variation. A standard measure set for use in the commercial ACO market has the potential of focusing resources on value drivers and health outcomes, while streamlining data collection and reducing reporting burden. Existing collaborations have included:

1. Measures recommended by Pacific Business Group on Health and Catalyst for Payment Reform (CPR) in their guide to Model ACO Contract Language
2. Measures used in the Integrated Healthcare Association (IHA) Value Based Pay for Performance Common Measure Set
3. Core Quality Measures recommended by America’s Health Insurance Plans, Centers for Medicare & Medicaid Services and the National Quality Forum

What follows is a proposed measure set developed with input from PBGH, CPR and IHA, including representatives from health plans, provider organizations, National Committee for Quality Assurance, RAND and other stakeholders. The measures that are bolded represent preferred purchaser measures for adoption and development.

---

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
</table>
| N/A   | Cervical Cancer Overscreening                     | IHA/NCQA| The percentage of women 21–64 years of age who received more cervical cancer screenings than necessary according to evidence-based guidelines, using either of the following criteria:  
• Women age 21–64 who had cervical cytology performed every 3 years.  
• Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. |
| 0034  | Colorectal Cancer Screening                       | NCQA    | The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.                                                                                                         |
| N/A   | Controlling High Blood Pressure                   | IHA/NCQA| The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. |
| N/A   | Statin Therapy for Patients with Cardiovascular Disease | NCQA    | The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:  
1. Received Statin Therapy.  
2. Statin Adherence 80%. |
<p>| 0068  | Ischemic Vascular Disease: Aspirin Use            | NCQA    | The percentage of patients 18 years of age and older who were discharged from an inpatient setting with an acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) during the 12 months prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of routine use of aspirin or another antiplatelet during the measurement year. |</p>
<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0071</td>
<td>Persistent Beta Blocker Treatment after Heart Attack</td>
<td>NCQA</td>
<td>The percentage of patients 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.</td>
</tr>
<tr>
<td></td>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0711</td>
<td>Depression Remission at 6 months</td>
<td>MNCM</td>
<td>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.</td>
</tr>
<tr>
<td>0418</td>
<td>Screening for Clinical Depression &amp; Follow Up Plan</td>
<td>CMS</td>
<td>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.</td>
</tr>
<tr>
<td>0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>NCQA</td>
<td>The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received initiation or engagement of AOD treatment.</td>
</tr>
<tr>
<td></td>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0729</td>
<td>Optimal Diabetes Care Combination</td>
<td>MNCM</td>
<td>The percentage of adult diabetes patients who have optimally managed modifiable risk factors to prevent/reduce future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c &lt; 8.0, Blood Pressure &lt; 140/90, Statin use unless contraindications or exceptions, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.</td>
</tr>
<tr>
<td>0731</td>
<td>Comprehensive Diabetes Care</td>
<td>NCQA</td>
<td>The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Hemoglobin A1c (HbA1c) testing (NQF#0057)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- HbA1c poor control (&gt;9.0%) (NQF#0059)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- HbA1c control (&lt;8.0%) (NQF#0575)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Medical attention for nephropathy (NQF#0062)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- BP control (&lt;140/90 mm Hg) (NQF#0061)</td>
</tr>
<tr>
<td>N/A</td>
<td>Statin Therapy for Patients with Diabetes</td>
<td>NCQA</td>
<td>“The percentage of members 40–75 years of age during the measurement year, with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Received Statin Therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Statin Adherence 80%.</td>
</tr>
<tr>
<td></td>
<td><strong>Low Back Pain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0052</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>NCQA</td>
<td>The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.</td>
</tr>
</tbody>
</table>
### Maternity

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0471</td>
<td>NTSV C-Section</td>
<td>TJC</td>
<td>Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section</td>
</tr>
<tr>
<td>1517</td>
<td>Prenatal and Postpartum Care</td>
<td>NCQA</td>
<td>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: Timeliness of Prenatal Care and Postpartum Care.</td>
</tr>
</tbody>
</table>

### Respiratory

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>NCQA</td>
<td>The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).</td>
</tr>
<tr>
<td>0058</td>
<td>Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis</td>
<td>NCQA</td>
<td>The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.</td>
</tr>
</tbody>
</table>

### Person Centeredness

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0005</td>
<td>CG-CAHPS (ACO)</td>
<td>AHRQ</td>
<td>The CAHPS Survey for Accountable Care Organizations (ACOs) is a version of the CAHPS Clinician &amp; Group Survey for accountable care organizations. The CAHPS Survey for ACOs expands on the measures generated by the core CAHPS Clinician &amp; Group Survey. Federal programs rely on either version of the ACO survey: ACO-9 and ACO-12.</td>
</tr>
<tr>
<td>0006</td>
<td>Patient Reported Outcomes</td>
<td>N/A</td>
<td>Defined roadmap and timeline for adoption of condition-specific patient reported outcomes such as HOOS (Hip disability and Osteoarthritis Outcome Score) or KOOS (knee injury and osteoarthritis outcome score) for joint surgery, average Change in Functional Status following Lumbar Spine Fusion Surgery (MN Community Measurement), or International Consortium for Health Outcomes Measurement (ICHOM) Standard Set for Pregnancy And Childbirth.</td>
</tr>
</tbody>
</table>

### Population Health

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0421</td>
<td>Adult BMI Screening &amp; Follow Up</td>
<td>CMS</td>
<td>Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI ( \geq 23 ) and ( &lt; 30 ) Age 18–64 years BMI ( &gt; ) or ( = 18.5 ) and ( &lt; 25 )</td>
</tr>
</tbody>
</table>
### Population Health (cont.)

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0038</td>
<td>Childhood Immunization Status: Combination 10</td>
<td>NCQA</td>
<td>Percentage of children 2 years of age who had four DtaP; three polio (IPV); one MMR; three HiB; three HepB; one VZV; four PCV; one HepA; RV; and two flu vaccines by their second birthday.</td>
</tr>
<tr>
<td>0033</td>
<td>Chlamydia Screening in Women</td>
<td>NCQA</td>
<td>The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.</td>
</tr>
<tr>
<td>1407</td>
<td>Immunizations for Adolescents</td>
<td>NCQA</td>
<td>The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.</td>
</tr>
<tr>
<td>0039</td>
<td>Flu Vaccinations for Adults 18-64</td>
<td>NCQA</td>
<td>The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.</td>
</tr>
</tbody>
</table>

### Utilization

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1768</td>
<td>All Cause Readmissions</td>
<td>NCQA</td>
<td>For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</td>
</tr>
<tr>
<td>N/A</td>
<td>ED Visits</td>
<td>NCQA</td>
<td>The number of emergency department (ED) visits during the measurement year.</td>
</tr>
<tr>
<td>N/A</td>
<td>Total Cost of Care</td>
<td>IHA</td>
<td>All costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.</td>
</tr>
<tr>
<td>N/A</td>
<td>AHRQ Prevention Quality Indicator #90: Ambulatory Sensitive Admissions</td>
<td>AHRQ</td>
<td>11-item composite constructed by summing the hospitalizations across the component conditions and dividing by the population. Rates will be adjusted for age and gender when comparing across regions or demographic groups.</td>
</tr>
<tr>
<td>N/A</td>
<td>Potentially Avoidable ER Visits</td>
<td>NYU</td>
<td>The number of potentially avoidable emergency department visits.</td>
</tr>
</tbody>
</table>

### Prevention

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure</th>
<th>Steward</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0028</td>
<td>Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>AMA-PCPI</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
</tr>
<tr>
<td>N/A</td>
<td>Use of Opioids at High Dosage OR Concurrent Use of Opioids &amp; Benzodiazepines (pending testing)</td>
<td>PQA</td>
<td>Percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines.</td>
</tr>
<tr>
<td>0024</td>
<td>Weight Assessment &amp; Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
<td>NCQA</td>
<td>Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: Body mass index (BMI) percentile documentation, Counseling for nutrition, &amp; Counseling for physical activity.</td>
</tr>
</tbody>
</table>
For more information

Have questions or would like to learn more about any of the information here?

• Contact us at PVNinfo@pbgh.org or visit www.PVNetwork.org

This toolkit is available electronically at:

• Full PVN ACO Toolkit: www.pvnetwork.org/storage/PVN_ACO_Toolkit_w_App.pdf
• Appendix I: www.pvnetwork.org/storage/App1_AssessmentGuide.pdf
• Appendix II: www.pvnetwork.org/storage/App2_SampleReport.pdf
• Appendix III: www.pvnetwork.org/storage/App3_SampleMeasures.pdf